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Citation for the original published paper (version of record):
Eriksson, E., Hellström, A. (2021). Multi-actor Resource Integration: A Service Approach in Public Management. British Journal of Management, 323(2): 456-472.
http://dx.doi.org/10.1111/1467-8551.12414

BJM BRITISH JOURNAL of MANAGEMENT
BRITISH ACADEMY OF MANAGEMENT
Check for updates
British Journal of Management, Vol. 32, 456–472 (2021)
DOI: 10.1111/1467-8551.12414

Multi-actor Resource Integration: A Service Approach in Public Management

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This paper addresses a service approach in public management by highlighting the insufficiently explored concept of resource integration. Specifically, we identify the actors who contribute to such integration, as well as the kind of resources they bring. The empirical material draws from two action research cases in cancer care, suggesting that, for complex challenges, resource-integrating actors may represent public, private and third-sector organizations, citizens/service users, as well as their private spheres. Moreover, resources may be both tangible and, more importantly, intangible. Because all actors in the system are doing the same thing – integrating resources – multi-actor resource integration frames interorganizational collaboration and citizen/user co-production. In contrast to the private sector's foci on profit and customer satisfaction, the gain herein concerns better usage of common resources and addressing public interests – such as access to services that meet the needs of disregarded groups. In the complex realities of contemporary societies, actors from all sectors should help meet such needs through collaborative resource integration rather than competition.

Introduction

Over the last few decades, countries and sectors have increasingly adopted new public management (NPM) ideas (Pollitt, 2007). At the same time, it has been argued that focusing overly on user satisfaction disregards important aspects of public services, such as the public interest of the collective citizenry (Stoker, 2006), while focusing on internal processes is argued to have led to the neglect of issues between organizations (Osborne *et al*., 2015), which has created fragmented welfare services and poor understanding of the system level (Quist and Fransson, 2014). To address the shortcomings of NPM, a service approach in public management was recently suggested (Grönroos, 2019; Osborne, 2018). In public management, theories addressing networks and collaborations between organizations (Addicott, McGivern and Ferlie, 2007; Klijn, 2010) are often separated from citizens'/users' contribution in co-producing services (Pestoff, 2014). By focusing on resource integration, these theories are framed as focusing on the collaborative efforts among a multiplicity of actors (Vargo and Lusch, 2016) – whether service users, friends and family, public authorities, private enterprises or non-profit organizations – to improve services and systems that may influence wellbeing for themselves and others (McColl-Kennedy *et al*., 2012).

The need for collaborative efforts is considered to be more important than ever (Mintzberg, 2015). Many contemporary societies face increasingly complex – or 'wicked' (Geuijen *et al*., 2017) – challenges that cut across organizational and sectorial boundaries (Bryson *et al*., 2017; Pollitt, 2003), caused by factors such as aging populations, pandemics, pollution and forced migration (Christensen, 2012; Geuijen *et al*., 2017). Because

The authors wish to thank Regional Cancer Centre West, Region Västra Götaland, Födelsehuset, staff and board of Kraftens hus (House of Power) and the anonymous reviewers for valuable comments on earlier versions of this paper, as well as comments received at the British Academy of Management, 5–7 September 2017.

A free Teaching and Learning Guide to accompany this article is available at: https://onlinelibrary.wiley.com/page/journal/14678551/homepage/teaching___learning_guides.htm

these issues concern entire societies, trusting the responsible public service organization (PSO) to address these challenges in a solitary and introspective NPM fashion is likely to do more harm than good (Crosby and Bryson, 2005; Radnor *et al*., 2014). Today's challenges call for increased collaborations to solve issues between organizations and sectors by building relationships across the service system (Bryson, 2004; Bryson, Crosby and Stone, 2015).

In a *British Journal of Management* special issue on public management, Ferlie, Hartley and Martin (2003) identified collaboration among organizations across sectors and citizen/user engagement as important areas for theoretical development. Ten years later, it was recognized that the above-mentioned areas had attracted some increased attention (Ashworth *et al*., 2013); for example, through the emerging service approach (Grönroos, 2019; Osborne, 2018).

The primary aim of this paper is to address a service approach with the purpose of offering an alternative way of managing public services and systems that are fit to address the complex challenges in contemporary society. More specifically, we highlight how resource integration – a concept that is central in the generic service literature, but has been insufficiently explored in public management (Skålén, 2016) – can be utilized to improve public services and systems to better meet the needs of citizens and users, while simultaneously addressing societal challenges caused by aging populations, forced migration and so on. Building on empirical material from two longitudinal action research cases, our objectives are (1) to identify the actors that contribute to such integration, and (2) to identify what kind of resources they bring. An overarching research question that coheres these objectives is: 'How can resource integration be utilized to improve public services and systems?' Ferlie, Hartley and Martin (2003) called for action research in public management. We argue that action research may reinforce the theoretical underpinnings of resource integration: the action researcher's knowledge and skills should also be integrated to improve public services and systems. Theoretical insights from public sector research also have the potential to inform private sector and general management research (not least through empirical cases), thus providing the called-for concreteness of resource integration in generic service literature (Zhang *et al*., 2015). This paper adopts a normative approach that seeks to contribute to public managers and policy makers by offering an alternative to predominant NPM ideas (Osborne, 2010).

A service approach in public management

Of the areas within public management that require theoretical development (Ferlie, Hartley and Martin, 2003), the service concepts that Osborne and colleagues revitalized have particularly addressed interorganizational collaboration and citizen/user engagement. *Public service-dominant logic* (Osborne, Radnor and Nasi, 2013) advocates a service approach in which public services cannot be produced and delivered (like goods) to service users, but are instead produced and consumed simultaneously during provider–user interactions. An alternative to this service approach to *co-production* is the public administration conceptualization, in which users may be invited to design public services. Combining the two approaches, Osborne and Strokosch (2013) suggested that citizens'/users' co-production also has the potential to impact the service system, not only the specific service. This systems perspective is further penetrated in the *SERVICE framework*, in which Osborne *et al*. (2015) emphasized the relationships between multiple actors in the system. The most recent concept is the *public service logic* (Osborne, 2018), which focuses on the distinctiveness of public sector services (compared to private sector services) and a shift in focus away from the PSO to the citizen/user as the arbiter of value.

Public service-dominant logic

Public service-dominant logic (Osborne, Radnor and Nasi, 2013) was developed to address the shortcomings of NPM, particularly the above-mentioned intraorganizational focus and the goods manufacturing focus. Osborne, Radnor and Nasi (2013) argued that Porter's (1985) value chain model was inappropriate for public management because it separated production and consumption, which relegated the customer to a passive role. Because PSOs predominantly concern public *services*, public management should borrow from service management rather than a goods

manufacturing logic, as argued by Osborne, Radnor and Nasi (2013).

In public service-dominant logic (Osborne, Radnor and Nasi, 2013), three characteristics were identified as important in public management: the intangibility of a service (as it is a process, not a thing); the inseparability of production and consumption for services; and, consequently, the user as a co-producer of services (Grönroos, 2007). In services, the staff–user interaction becomes essential because co-production occurs in these micro-level service meetings (Hardyman, Daunt and Kitchener, 2015). In addition to the service characteristics of inseparability, intangibility and co-production (Grönroos, 2007), Osborne, Radnor and Nasi (2013) highlighted knowledge transformation recognizing that tangible goods should be seen as enablers of intangible public services (Osborne, Radnor and Nasi, 2013), such as rehabilitation following instructions on a computer (Osborne *et al*., 2015).

Co-production

In a service approach, production and consumption occur simultaneously (Pestoff, 2014; Radnor *et al*., 2014). However, co-production in the public administration literature is optional, in that citizens/users may be invited to help design and improve existing public services by sharing their needs, expectations and experiences of the service (Farr, 2016; Osborne and Strokosch, 2013). By combining public administration's co-production with service management's co-production and focus on the service meeting, Osborne and Strokosch (2013) proposed a third mode of co-production – enhanced co-production – in which co-production means producing 'the potential for transformational effects upon the public services delivery system as a whole – user-led innovation of new forms of public service delivery' (Osborne and Strokosch, 2013, p. 39).

SERVICE framework

The SERVICE framework focuses on public services as systems rather than as being restricted to single organizations (Osborne *et al*., 2015; Radnor *et al*., 2014). Many interorganizational collaboration concepts developed in the late twentieth century focused on the organizational level (Osborne *et al*., 2015). In a public service-dominant fashion, the systems that deliver public services must also consider service users, their families and communities. Thus, managing the relationships among multiple actors within these systems becomes central and trust is key in building these relationships (Osborne *et al*., 2015). Rather than relationships on the organizational level, the SERVICE framework emphasizes the individual level, 'where the staff of a PSO interact with policymakers, the staff of other PSOs and service users' (Osborne *et al*., 2015, p. 430).

Public service logic

In the recent *public service logic*, Osborne (2018) dropped '-dominance' to connect public service logic closer to service logic, which focuses on relationships of value creation (Grönroos, 2011). This shift also indicated a need to distance public services from private services. Examples include the different meanings of 'returning customers' to a private company compared to a drug rehabilitation centre, the unwillingness of some public service 'customers' (prison inmates) to collaborate and the potential conflict between the service user's notion of value addressing personal needs and the citizen's notion of value addressing societal needs (Osborne, 2018).

It is not sufficient to focus on relationships of value creation at the interorganizational level; more focus should be put on PSOs' relationships with citizens/users (Osborne *et al*., 2015). Rather than implying a shift from organization-to-organization to organization-to-user, this argument indicates a focus on relationships among multiple actors in the broader service system, suggesting an actor-to-actor approach in recent service approaches in public management (Skålén *et al*., 2018). However, this aspect remains underdeveloped in a public sector context.

Resource integration

In generic service-dominant logic, 'service' is defined as 'the application of specialized competences (knowledge and skills)' (Vargo and Lusch, 2004, p. 2). Similarly, in generic service logic, 'service' is understood as a verb, with interactional and relational aspects being central (Quist and Fransson, 2014). Consequently, interactions and relationships must be established to enable the integration of resources between actors (Normann,

2001). However, the concept of resource integration among multiple actors has not been thoroughly elaborated within public management. Calls have been made for an increased understanding of joint value creation (O'Cass and Ngo, 2011; Voorberg, Bekkers and Tummers, 2015), guided by the needs of the service user, both within a service approach to public management (Osborne, 2018; Skålén *et al*., 2018), as well as in generic public management literature (Bryson *et al*., 2017).

All actors within the service systems, including citizens/users, are resource integrators and co-creators of value (Akaka, Vargo and Lusch, 2013). Because value is synonymous with increased wellbeing in a service approach (Vargo, Maglio and Akaka, 2008), the main service provider is rarely the only contributor to the user's wellbeing (Sweeney, Danaher and McColl-Kennedy, 2015). Instead, in a systems perspective the citizen/user combines the main provider's resources with those of other actors and transforms them into increased wellbeing (value) in their everyday lives (McColl-Kennedy *et al*., 2012). Thus, a service approach highlights the importance of PSOs knowing which other actors the citizen/user integrates resources from, and how these resources are combined and applied in their broader life worlds (Quist and Fransson, 2014), particularly intangible resources (knowledge, skills and information) (Edvardsson, Tronvoll and Gruber, 2011). Contrary to NPM, the focus here is on what happens for the user rather than what happens within the organization (Osborne, Radnor and Nasi, 2013). In a healthcare context, such a holistic view includes more than the healthcare episode, so it becomes important for the provider to reconfigure how to support the patient's greater picture (Quist and Fransson, 2014).

Method

Two action research cases in Swedish cancer care

This study is set in Sweden, a country whose healthcare system is very familiar to both authors. As in many Western countries, aging populations and medical and technical advances have increased the number of people living with cancer in Sweden (Cancerfonden, 2015). As of 2013, one in three Swedes was expected to develop cancer during their lifetime, and this incidence is predicted to double by 2030 (SC, 2013). Despite relatively good medical results (Coleman *et al*., 2011), patient involvement in Swedish cancer care is modest compared with other countries (SKL, 2015). The decentralized nature of Sweden's healthcare systems is one reason why some patients face fragmented services that are difficult to navigate (Hellström *et al*., 2015). In Sweden, the national level offers guidelines and recommendations, the regions are responsible for offering their inhabitants basic primary care and specialized care at hospitals, and the local municipalities are responsible for caring for the elderly in their homes or in special accommodations (SFS, 2017). Addressing the increasing number of cancer patients and organizational obstacles, a national cancer strategy was launched in 2009 (SOU, 2009) for the first time in Sweden, highlighting the need for new ways of thinking, including holistic/systemic approaches that address the complexity of the challenges.

In the cases addressed in this paper, the researchers worked with various actors to bring about changes in unsatisfactory situations. A cornerstone of action research is that it is carried out collaboratively *with* practitioners (Bradbury, 2010). The actors to include in action research are often found within a broader context rather than within just one organization (Coghlan and Brannick, 2010). Both cases were studied in a collaborative fashion that included multiple actors in scattered systems representing, among others, traditional healthcare (physician, nurses, midwives), private actors (from small to large businesses), community members, (former) patients, authorities and third-sector actors. The shared ambition of achieving change in this scattered system created an intervention that Eden and Huxman (1996, p. 80) referred to as:

> … opportunities for experimentation and to try out complex theoretical frameworks that cannot be pulled apart for controlled evaluation of individual theories. This is important in management research where it is often the systemic nature of a uniquely interlocking set of theories from many disciplines that makes the body of theory powerful and useful.

Another important aspect of action research is achieving change and improving social practice (Brydon-Miller, Greenwood and Maguire, 2003). Here, a driving force in many inquiries is to address inequities, such as inadequate access to public services (McIntyre, 2008). In both of the provided cases, inequities were a starting point: in Case A, an authority's failure to enable women in a

multicultural area to make informed decisions about whether to take a test; in Case B, the absence of a service focusing on aspects of life other than the disease. In both cases, it was important to include the knowledge and skills of people directly concerned (locals, (former) cancer patients) when designing services that were likely to meet the needs of other members of that group, as well as empowering participants (Coghlan and Brannick, 2010).

Both authors were 'outside' action researchers, given that neither worked 'inside' the main organizations or community in which changes and innovations were sought (Coghlan and Brannick, 2010). As outside researchers, we brought systematic inquiry and analysis into the respective projects. In the cases, the researchers' tasks involved literature reviewing and benchmarking, suggesting data collection and analysis methods and enabling and encouraging collaborations. The knowledge from the 'inside' was provided mainly by the community representatives and healthcare staff (Case A) and cancer patients, their relatives and the relevant authorities (Case B). As outside researchers, we also integrated reflective dialogue sessions during the project to create locally relevant theories that were tested and continuously emerged (Eden and Huxman, 1996).

Data collection and analysis of the separate cases

In both cases, interpretation and analysis of data, as well as some data collection, was carried out collaboratively with members of the system (Brydon-Miller, Greenwood and Maguire, 2003). This procedure was also important in order to validate that nothing was misunderstood (Greenwood and Levin, 2007). Qualitative data was collected through the researchers' field notes, diaries from staff working in the field, observations during outreach activities between local representatives and healthcare staff and in various meetings with system actors. In Case B, design workshops and dialogue meetings with the whole system in the room (Huzzard, Hellström and Lifvergren, 2017), inspired by appreciative inquiry (Cooperrider, Whitney and Stavros, 2005) and emotional mapping sessions (Donetto *et al.*, 2015), were also used. The latter involved the patients/relatives applying positive and negative emotion words to the key points in their lived experience, from receiving the diagnosis to their present status. With all individual 'emotional journeys' as a basis, the patients/relatives collectively created visual maps that facilitated a shared reflection on the emotional impacts in different stages. This was done in groups of four to six people for 1.5−2 hours. The discussions within the groups were recorded and analysed, together with the emotional maps. In Case A, quantitative data on project outcome (participation rate in a screening programme) were also collected and analysed during the project using control charts (Bergman and Klefsjö, 2010).

In Case A, two focus groups were the primary data collection method, focusing on local immigrant women's opinions and for observing relationships and group dynamics (Morgan, 1996; Saint-Germain, Bassford and Montano, 1993). Questions were asked based on public health literature (especially research addressing improvements of disease prevention services in disadvantaged communities) and literature on quality and service management. The focus group sessions were semi-structured, took 1−2 hours and were recorded and transcribed verbatim. In Case B, seven workshops were carried out with patients, relatives and representatives from relevant actors in the life of a cancer-affected person (healthcare, local politicians, social insurance agencies, municipalities, etc.). Between 9 and 51 people participated in these workshops. Questions in these sessions focused on the members' perceptions of being 'affected by cancer' and their perceived needs, but also on what useful resources they could identify in the 'system'. These workshops were documented and analysed by researchers and cancer-affected people. Primary data collection for Case B were 21 semi-structured interviews that centred around the interviewees' participation in the workshop series. Questions were related to service management theories in the above literature review section. The background of the participants in the two cases' primary data collection methods are shown in Table 1.

The data was analysed using an inductive approach inspired by content coding (Graneheim and Lundman, 2004) and conventional content analysis (Hsieh and Shannon, 2005). The transcriptions were read through and recordings were listened to repeatedly in order to obtain a sense of the whole. Codes were derived by going through the data and were sorted into various categories based on similarities and differences. The categories were clustered into various themes

Table 1. Background of participants

Case	Data collection method	
Case A	Semi-structured focus group	4 (all local women, so-called doulas)
	Semi-structured focus group	9 (all local women, so-called doulas)
Case B	Semi-structured interviews	21 (16 women, 5 men; 9 patients/relatives, 12 organization representatives)
Total		**34**

(Graneheim and Lundman, 2004; Miles and Huberman, 1994); practical issues and lack of information were examples of themes of barriers of participating in the cancer prevention programme (Case A), and unmet psychological and social needs during and after cancer care (Case B). Case A also had an abductive element (Dubois and Gadde, 2002), as the experiences of the launched interventions in the local context were fed back and modified the initial themes of successful interventions that had been similarly retrieved from focus groups as well as from the literature.

Data analysis when merging the cases

Both cases had an atypical focus on aspects of healthcare other than the predominant curing and caring (Mintzberg, 2017): cancer prevention and life situation after cancer. Because both projects were also embedded in complex contexts such as aging societies (Lifvergren *et al*., 2012) and immigration (Eriksson *et al*., 2016), the healthcare system alone would not meet the service user's needs. Rather, the two authors' conclusions from the above-mentioned cases were that the multiplicity of actors' resources and how they were integrated needed to be better understood.

The joint analysis of the two cases was conducted more deductively than had been the case for each separate case; therefore, thematic analysis similar to template analysis (Brooks *et al*., 2015; King, 2012) and directed content analysis (Hsieh and Shannon, 2005) was used. In the first phase, tentative a priori themes were constructed based on previous experiences (Alvesson and Sköldberg, 2009) and literature from service management and resource integration (Akaka, Vargo and Lusch, 2013). These themes were connected to the objectives of the paper to show how resource integration can be utilized to improve public services and systems. During the initial rereading of some of the empirical material, the tentative themes were omitted, modified or expanded, with new themes that were developed into an initial template. The template and its themes were then tested and refined as the remaining empirical material was analysed (Brooks *et al*., 2015; King, 2012). The final themes are specified under the second and third subheadings in the discussions section and focus on who participates in resource integration and what knowledge they have. See Figure 1 for the coding structure for concepts (expressions close to the focus groups/interviews in the empirical material), final themes and overarching dimensions (related to the paper's objectives) in the cross-case analysis.

Findings

This section offers two cases of how multi-actor resource integration may work in practice. The first case describes a longitudinal 2-year project with the first author as the lead researcher, while the second author played a more distant advisory role. The aim was to increase understanding of barriers to participate in a cancer screening programme among immigrant women and to improve the cancer prevention service collaboratively. This case explains how actors within and outside healthcare may collaborate in resource integration to raise awareness of cancer prevention in a multicultural area. The second case was taken from an ongoing project that started in 2016, with the second author as the lead researcher and the first author playing an evaluative role in the project's early phase. The aim was to identify the needs of people affected by cancer and to develop a new service that met those needs that the welfare system had failed to meet. Resources were brought in from actors across sectors to design a service that acknowledged the broader life situations of people affected by cancer.

Case A: Bring a Friend

Our first case describes how a local cancer screening programme was redesigned to prevent local

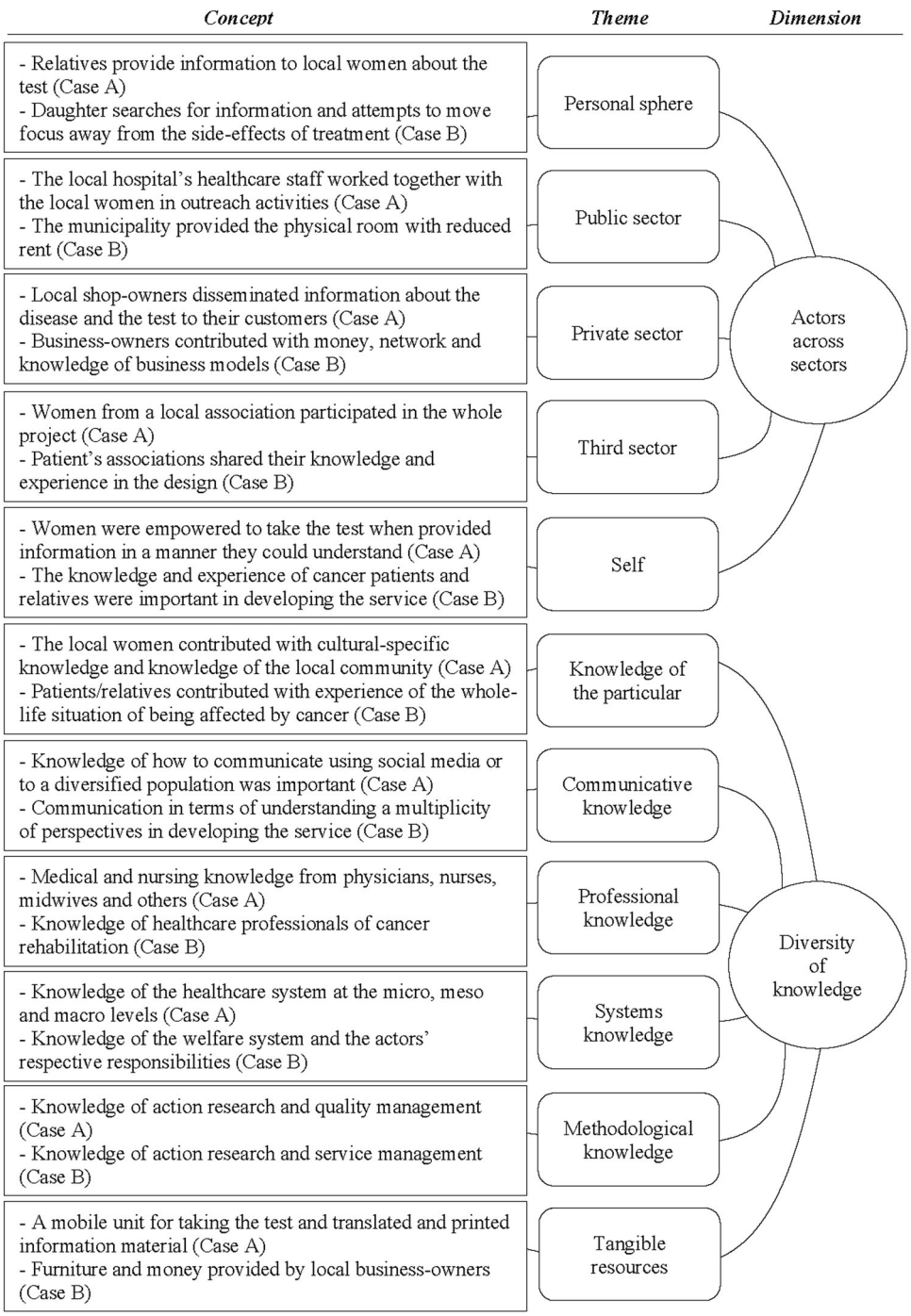

Figure 1. Coding structure

women from developing cervical cancer. This project won a national award for most innovative healthcare project in 2012.

Half of the people in the North-eastern sections of Gothenburg, Sweden's second largest city, are foreign-born (Göteborg, 2013). The area suffers from high unemployment and poverty rates and various poor health indicators (Göteborg, 2010). Similarly, participation rates in the cervical cancer screening programme were 57–64%, compared to

82% in the Western region of Sweden (OC, 2011). The standard practice of sending out invitations with a pre-booked appointment time did not seem to attract local women to visit the clinics, even when the invitations were translated into many languages.

Talking with local representatives and healthcare staff provided a more nuanced picture of the local area, often problematized in the media, particularly regarding a number of well-established arenas for communication in the local area, such as associations and informal venues. In order to increase knowledge about and gain access to these arenas, the local *doulas* were involved in the project. The doulas had already worked for a local association supporting parents prior to, during and after delivery, and functioned as interpreters (of language and culture).

The doulas contributed with local knowledge, skills and cultural knowledge. The experiences of local midwives, nurses and gynaecologists were also included in the project, as they were important for improving the screening programme. The gynaecologist and midwife of the regional cancer organization that was facilitating the screening programme were also included, providing experience and professional knowledge, but also a mandate for the project.

Interventions were launched over a 1-year period in 2011–2012. The doulas proved to be central to the integration of the resources. They included their own 'lived experience' as foreign-born women living in the local area, providing support to parents before and after delivery, but also their own extended networks in the communication of cervical cancer prevention. These included associations for certain ethnic groups, but also informal venues that were important for people to gather and talk, such as a local hair salon: 'Most of them don't even cut their hair. That's where they meet to drink coffee and to talk about things' (doula). After sessions with the regional midwife, the doulas were sent to talk with locals about the basics of cervical cancer and how the test could help, but also about practical issues, including where and when to take the test. It was clear that the doulas had already gained trust among the locals, which enabled them to reach out in a way that healthcare staff could not: 'When they recognize us, they feel confident to ask questions' (doula). The staff at the local clinics offered professional skills to the project. In particular, when working together at local squares and shopping malls, the doulas' and midwives' knowledge was complementary. The locals were also informed through social media, particularly through the recording and sharing of three short films (in Arabic, Somali and Swedish) about the importance of the test, created by a third-sector association. The first author acted as co-project manager, suggested appropriate methods for the project and contributed with systematization in the improvements.

During the project, participation in the screening programme increased by 42%. However, the main objective of the project was not to increase participation, but to *enable* local women to make an informed decision about whether to take the test. This was important because the doulas had noticed that it was often an uninformed decision not to take the test: 'They have no idea what it [the test] is' (doula). Through this project, many women were given medically accurate information in their own language from the doulas and midwives working together. Hence, oral information, whether face-to-face or through films, was favoured over written documents. Integration of resources from various actors and sectors proved important when disseminating information to locals about preventing cervical cancer.

Case B: House of Power

A cancer diagnosis can affect a person physically, mentally and socially, including pain, lymphedema, nausea, depression, economy, family, sexual health and existential anxiety (Cancerfonden, 2015). A patient will require rehabilitation in order to be able to return to work and have a well-functioning life during and after cancer. The patient and the healthcare provider are rarely the only actors in this process, as was evident when the patient was discharged from hospital: '… when we are finished, there's a huge void' (physician). Therefore, well-functioning collaboration is necessary between the many different organizations that are involved in the life of the person affected by cancer (hospital, primary care, social insurance agency, employer, civil society, municipal services, etc.). Depending on the patient's life situation, the number of involved organizations may vary. This 'jigsaw puzzle' of different actors that each cancer patient and their next of kin must create is frustrating, energy-consuming and a major reason for unequal cancer rehabilitation and return to a

new normality. The aim of the *House of Power* project was to integrate societal resources in a way that better suited the needs of people affected by cancer. It was the first Swedish support centre for people affected by cancer – initiated and designed by and for cancer-affected people. By establishing a new independent non-profit organization, this grassroots initiative addressed social needs that the market or the public sector did not.

The project used a 'life event perspective' (Innovationsrådet, 2011) as a starting point to identify individuals' needs. The life event 'getting a cancer diagnosis' starts with a cancer diagnosis, but includes more than just the disease. It is fruitful for a cancer patient to identify all the relevant actors and see the complexity of the situation. It helped to identify inadequate coordination between actors that was important for the person concerned, but also offered the opportunity to find new solutions and identify new players that could contribute.

Based on the life event perspective and its generated map of relevant actors, the *House of Power* created a network with representatives including patients, relatives, the hospital, politicians from the municipality, primary care, the social insurance agency, the public employment service, patient associations and representatives from some of the major local employers. Focal needs included meeting other people in the same situation (something that hospitals could not facilitate due to confidentiality): 'People who never had cancer can have an idea, but they cannot fully understand how it is to live with cancer' (patient). Needs also included receiving support, sharing stories and experiences, finding positive role models/compassion/empathy/sympathy, curing loneliness, having a place that enabled spontaneous meetings and conversations and learning to live with cancer. None of these needs were obvious responsibilities for any of the involved PSOs, but were critical for timely and healthy rehabilitation, as well as for a healthy lifestyle for patients, recovering patients and patients with chronic diagnoses.

Within the network, the meaning of 'affected by cancer' also expanded to accommodate the breadth of how different people – patients, partners, children, officers at agencies, healthcare staff, employers, etc. – could be affected by a cancer diagnosis. To develop the *House of Power* concept, the image of the new, desired state was created via collaboration in design workshops over 6 months. With the whole system in the room (Huzzard, Hellström and Lifvergren, 2017) during these workshops, the actors could talk and show a joint understanding of what resources would be required and how the typical interaction patterns could appear.

The business model was based on resource integration, whereby the organization had access to the resources without necessarily owning them. The aim was not to add any larger extra resources, but to integrate existing resources in a more appropriate way for the target group. Financial support was received from the regional public healthcare provider, the municipality, local businesses and the National Cancer Fund. These constituted a financial platform for the *House of Power*, where other actors could contribute with resources in other forms – such as activities, competence, information, equipment and staff employed by other organizations. Relying on financial and other resources from multiple actors was believed to make the *House of Power* less vulnerable if one actor abandoned it: 'One needs to stand on more than one foot when doing things like this' (politician). Moreover, collaboration among the involved actors had increased overall because of the *House of Power*: 'When meeting in the way we have done, it becomes easier to phone someone' (agency representative).

Discussion

Multi-actor approach

This paper is normative in that a service approach to public management is argued to be a much-needed strategy, particularly when recognizing the diversity of actors that participate in resource integration and the kind of resources they possess. Unlike NPM's focus on the efficiency of internal processes and market competition (Andersson and Liff, 2012), a multi-actor service approach may better address complex challenges (Bryson *et al*., 2017; Geuijen *et al*., 2017), caused by aging populations and forced migration. Both of the cases in this paper reveal a major flaw in NPM: the neglect of issues between organizations, poor understanding of the system level and, consequently, fragmented welfare services from the citizens'/users' perspectives (Quist and Fransson, 2014). Thus, public services should be understood as systems and not restricted to single organizations (Radnor *et al*., 2014).

Similar to studies of interorganizational collaborations (Christensen, 2012; Koliba *et al*., 2017), our findings suggest that informality and non-hierarchy were important aspects in designing services for cancer prevention and for people affected by cancer. For example, managing relationships (Osborne, Radnor and Nasi, 2013) and trust (Klijn, 2010) among the involved actors has been highlighted as important. The empirical material suggests that, through resource integration, actors may gain trust in one another and build relationships; for example, by working in outreach activities to improve cancer prevention (Case A) or by addressing obstacles for cancer-affected people (Case B). Similar to the SERVICE framework (Osborne *et al*., 2015), relationships were mainly addressed at an individual level rather than an organizational level. However, hierarchy (or 'vertical coordination'; Agranoff and McGuire, 2003) was apparent in both cases by the mandate provided by the responsible officials at the over-riding cancer organization. In the long run, vertical coordination could lead to increasing use of top-down aspects, as reported in other public management collaborations (Addicott, McGivern and Ferlie, 2007; Span *et al*., 2012).

Unlike some interorganizational concepts (Addicott, McGivern and Ferlie, 2007), but similar to others (Bryson, Crosby and Stone, 2015), a service approach includes collaboration across the service system, which includes not only PSOs but also citizens/users, their families and communities, as well as private and third-sector organizations (Osborne, 2010; Osborne *et al*., 2015). The empirical material suggests that involvement of citizens/users goes beyond NPM's choosing among providers, which is believed to indirectly lead to improved services (Anttiroiko and Valkama, 2016). Rather, their involvement concerns the direct efforts to improve/design services. Thus, citizen/user involvement in both cases is similar to co-production of public administration (Ostrom, 1996). By extension, however, the involvement of citizens/users is expected to result in improved co-production of service management (Normann, 2001): improved staff–user interactions (Hardyman, Daunt and Kitchener, 2015), as well as other benefits reported in the healthcare literature, including empowerment, participation in decision-making and self-care (Snyder and Engström, 2016). Citizens/users may also be involved not only in co-producing existing services, but also in developing new forms of service delivery within service systems (Farr, 2016; Osborne, Radnor and Strokosch, 2016).

Resource integration: actors across sectors

In a systems perspective, a single provider cannot produce and deliver value to service users (Normann, 2001). Rather, the users combine various actors' resources in their efforts to create value (increased wellbeing) in their broader life worlds (Grönroos and Voima, 2013). From the providers' perspective it becomes important to understand which other actors service users integrate resources from and how these are combined in their everyday lives (Quist and Fransson, 2014). Both the service approach (Osborne, 2018) and the broader public management literature (Bryson *et al*., 2017) have called for increased understanding of the service user's needs as guiding actors' collaboration. The importance of such a user-centred approach is evident in both cases. The starting point in Case A was the women in a segregated area making an informed decision about whether to take a test or not. In Case B it was the people affected by cancer. The initial steps sought to understand the individuals' life situations and be empathetic. In Case A, this meant trying to understand everyday life in a segregated area. In Case B, it meant trying to understand the emotional, social and practical situation of being affected by cancer. This was done with the explicit involvement of users and their social contexts. Case B used emotional mapping techniques (Donetto *et al*., 2015). With this deep understanding of the users' situations as a basis, the 'system' was expanded in order to identify potential resources. However, despite the user-centredness, an actor-to-actor approach is suggested in both cases; that is, all actors within the service system are considered to be collaborating resource integrators (Akaka, Vargo and Lusch, 2013). An actor-to-actor approach is deemed to be an important intermediary level between an overly unilateral focus on 'customers', such as NPM's customer satisfaction (Stoker, 2006), and too much focus on the organizational level (Osborne *et al*., 2015).

Despite the centrality of intangible resources in a service(-dominant) logic, it is rarely specified what this includes, other than knowledge, skills, information and the like (Edvardsson, Tronvoll and Gruber, 2011). From the two empirical cases,

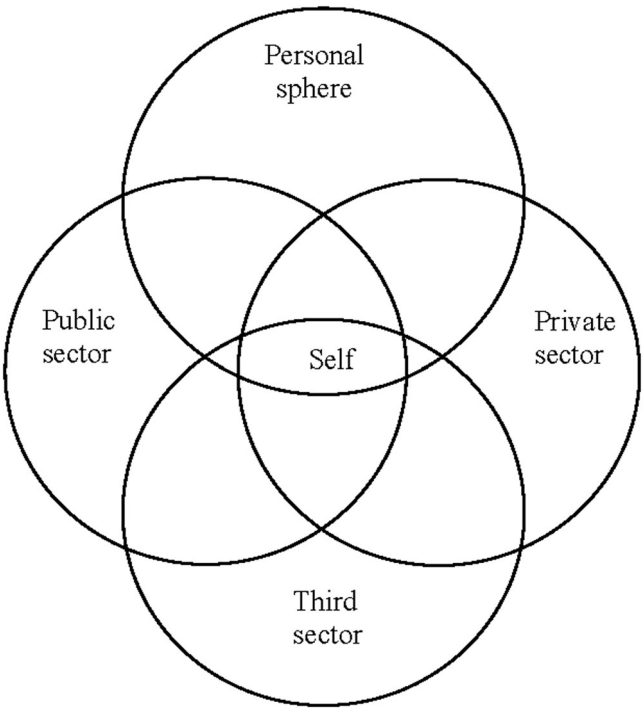

Figure 2. Resource integration among actors across sectors

we identify several intangible resources that were integrated and combined to create services that better met people's needs. As Figure 2 shows, intangible resources came from public, private and third-sector actors, as well as from the users themselves and their personal spheres.

Resources from the *personal sphere* include those possessed by family members, friends and other users. In Case B, other cancer patients' resources were pivotal, including sharing of experiences, curing loneliness and learning to live with cancer. Broadening 'cancer-affected' to include family members and friends meant that these actors were considered important in terms of providing empathy and compassion. The name of Case A – *Bring a Friend* – emphasized the potential of the personal sphere. Here, women were encouraged to bring a friend whilst taking the test, both to provide comfort and to look after the women's children.

Resources from the *public sector* were mainly provided by healthcare professionals. In Case A, gynaecologists, nurses and midwives contributed with medical and nursing knowledge, which was important for helping local women make informed decisions. The healthcare providers at different levels also contributed with practical knowledge about how the screening programme functioned, which was important to understand when trying to change it. Involving the healthcare provider who facilitates the screening programme gave the team a mandate to try innovative ways of organizing it locally. Information officials within the regional healthcare organization contributed with important knowledge about how, where and when to communicate the message. Moreover, municipal staff working with health promotion were important in terms of informing locals about cervical cancer prevention. In Case B, the number of actors from the public sector broadened to include national agencies such as the social insurance agency, the public employment service and various municipal services, all of which were considered crucial when addressing the life event of getting cancer.

In both cases, resources from the *private sector* were evident. Regarding Case A, it was mainly local shop owners who participated in the dissemination of information; they were already established nodes in the local area for people to gather and talk in a relaxed way. Private actors also contributed, with the project's logotype and design of information material. In Case B, representatives from the private sector engaged in the design of workshops,

contributing knowledge about creating business models and plans. They were also among the financiers of the organization's financial platform and have two seats on the board. None of the representatives came from businesses that provided care, health or counselling, and therefore they could have business interests in the development of the *House of Power*.

Resources from the *third sector* were pivotal in both projects. In Case A, the doulas themselves represented a local association. Being well established locally gave the doulas a mandate among the locals to talk about healthcare issues. Moreover, members of local associations, which were often organized around country of birth and the like, showed interest and participated in fruitful dialogue, often together with the doulas and healthcare staff. A third-sector organization was important because of its ability to produce and spread short films. In Case B, the third sector was represented primarily by patient associations that had important cumulative knowledge of the obstacles that people affected by cancer experienced.

Resources from *self* were also integrated. In Case A, the main barrier preventing women from taking the test was that they simply did not know about cervical cancer and its prevention. However, the doulas reported that many of the women they encountered had been informed about this and were empowered to make an informed decision. In Case B, knowledge of patients and former patients was crucial in identifying important aspects to include in a service addressing the whole-life event of getting cancer.

Resource integration: diversity of knowledge

We agree that, rather than 'occurring', collaboration must be managed (Agranoff and McGuire, 2003). As we have suggested, neither the (local) government (Klijn and Koppenjan, 2000) nor the public manager (Crosby and Bryson, 2005, 2010) can be expected to take the initiative to manage services for which responsibility is unclear (Quist and Fransson, 2014). Both cases fall outside the main responsibilities of traditional healthcare. Consequently, when the objectives are to prevent people from getting sick or to deal with the life event of getting cancer, NPM will not suffice. First, value cannot be produced and delivered to people, simply because the expertise required will not solely be found within the medical or nursing professions. Expertise and experiences often come from a variety of actors, such as family members, private companies or associations. Thus, a service approach may be suitable for organizing healthcare requiring resources from multiple actors across many sectors. As we have argued, action researchers may facilitate relationships and integrate resources that had previously been highly under-used or not interconnected. This subsection presents examples of knowledge as an intangible resource found in the two cases.

Knowledge of the particular was important in both cases. 'The particular' is interpreted here as knowledge about the 'local community' (Case A) and knowledge and experience of 'getting cancer' (Case B). In the former, the doulas had knowledge of already established nodes in society in which dialogue should take place, as well as cultural-specific aspects. In the latter, (former) cancer patients and their families knew the whole-life situation of getting cancer, and therefore about aspects that were important to include in designing a service to meet those needs.

In both cases, *communicative knowledge* was crucial in terms of reaching out with information. In Case A, information officials were important because they informed the public and the involved organizations about the progress of the project. Together with private actors, the officials also developed printed material for locals. Social media was used to spread information, including three short films that were produced and sent out by a third-sector organization. Oral information proved essential, not least because of the doulas' abilities to communicate in the women's mother tongues. Along with knowledge of the particular, communicative knowledge is crucial in addressing where, when, how and to whom to communicate.

Given the multiplicity of actors, some resources *intermingled with and reinforced* one another. For example, in Case A, the doulas and midwives worked together in outreach activities in public places. The midwives provided *professional knowledge* related to cervical cancer prevention and communicated it effectively together with the doulas, who knew how to communicate in the women's mother tongues. Case B is about mutually reinforcing knowledge. Preventing people affected by cancer from falling between the cracks of organizations requires authorities and other actors to provide joint solutions. Indeed, the actual design workshops in Case B were about creating an

understanding of each other's responsibilities and intermingling resources. Even though collaboration between PSOs is increasingly formalized in Sweden, the informal aspects were at the heart of both cases, enabled through relationship building and trust based on increased understanding of each other's perspectives. An important unifying factor in both cases was focus on the whole-life situation of the locals and the cancer-affected, respectively.

In both cases, little was known prior to the projects about the overarching system within which resource integration should occur. In Case B, it was evident that (former) patients were experts about *their* journey but that an understanding of the system as a whole was often lacking. In both projects, collaboration among multiple actors increased *knowledge about the systems* but also increased respect for the complexity. The potential width of such systems is worth recognizing, including actors representing different levels (local shops, national players), different sectors and possessing different types of knowledge as described in this section.

In our experience, multi-actor initiatives are likely to be messy and benefit from what we call *methodological knowledge*. Both authors, as researchers, contributed this type of knowledge to both projects. Bringing academic knowledge from fields including organizational research, quality management, service management and action research helped bring the projects forward at the same time as acknowledging the complexities within which both projects took place. Training in the systematization of data collection and analysis helped the authors identify the 'particular' problem and encourage participation and ideas for improvements among participants. Thus, based on the experiences of the provided action research projects, as well as other similar projects, we argue that another important role for action researchers is that of orchestrators of innovations. There seems to be a lack of responsibility and 'ownership' for issues addressing innovations and improvement work within public services that spreads over many actors and sectors. Consequently, it may often be unclear who should take the initiative for action when improving these types of public services. Here, we believe the action researcher can play an important role.

While intangible resources are central in resource integration (Vargo and Lusch, 2008), tangible resources are also important and were included in both cases. For example, Case A used a mobile unit that enabled tests to be taken in public places, while in Case B, private actors were important in providing facilities, furniture, equipment, etc. The tangible resources had no inherent value but were regarded as enablers of intangible public services (Osborne, Radnor and Nasi, 2013). However, we argue that, in both cases, people's intangible resources were key and are crucial in similar multi-actor projects.

Conclusion

The theoretical contribution of this paper has been to contribute to a service approach in public management by highlighting the underdeveloped concept of resource integration. Based on two empirical cases, we suggest an actor-to-actor approach in which all participating actors in the service system are doing the same thing: integrating resources, particularly intangible ones, with one another. We have provided examples of participating private, public and third-sector actors, as well as the citizens/users themselves and actors from their personal sphere such as family, friends and the local community. The intangible resources include knowledge of the particular situation, communicative knowledge, professional knowledge, systems knowledge and methodological knowledge; some of these should be understood as mutually reinforcing. Consequently, multi-actor resource integration frames interorganizational collaboration and citizen/user co-production.

We suggest that public management may benefit from approaches (such as resource integration) and tools (such as business models) that have been developed mainly with the private service sector in mind. However, unlike in most private services, 'customers' in public services may sometimes be reluctant or emotionally/physically exposed (during counselling or examinations, for example), or at risk (during surgery, for instance). Moreover, public service users (such as prison inmates) and citizens may have conflicting ideas about a particular service, which may satisfy users but harm the public interest. Such situations require increased knowledge of the specifics of resource integration within welfare services, which this paper has contributed to.

The benefits of resource integration highlighted in this paper lie in making better use of common resources and improving outcomes. We contribute to general management studies set in the private sector by emphasizing aspects of outcomes other than profit and satisfied customers. More specifically, because the resources of a diversity of actors across sectors are necessary when addressing complex issues of societal concern (such as pollution, alienation and sick leave), private actors should also contribute to outcomes in terms of public interest (equality and access to services) that is reached through collaboration, not competition. The theoretical contribution is also to the generic service(-dominant) logic's resource integration, by providing the concreteness that Zhang *et al*. (2015) called for.

The practical contribution of this paper is that policy makers and public managers should be aware of and use ways other than the introspective NPM of managing public services. The empirical material suggests that a service approach in public management which explicitly recognizes all actors as resource integrators and favours intangible resources is suitable for addressing complex challenges in today's societies. We do not suggest that a service approach should replace NPM, but that different approaches are needed when addressing different types of challenges.

Methodologically, the use of action research in public management is one way to 'try out complex theoretical frameworks' (Eden and Huxman, 1996, p. 80). Moreover, action researchers are regarded as resource-integrating actors whose academic knowledge and skills can help improve the service or system. When two or more researchers conduct multiple case studies, a fruitful strategy, as used in this paper, may be to change positions as being more or less close to the case. This approach increases the likelihood of having a distanced and critical perspective yet keeping the closeness to the studied phenomenon. For complex issues in which responsibility may be unclear, action researchers may act as facilitators or orchestrators of resource integration. However, action researchers as orchestrators of multi-actor resource integration can be problematic. When the researcher moves on to new projects or when other tasks jostle for attention, who can take over? The sustainability aspect of similar action research initiatives could be investigated further.

One risk of an actor-to-actor approach is that the user focus may be lost among the diversity of actor perspectives. We have raised awareness of this risk by highlighting the importance of focusing on the user's needs in these types of projects. More critical reflections on a service approach in public management are needed in order to explore *how* resource integration occurs; for example, power asymmetries among resource integrating organizations, professions and between providers and users. Overall, further studies could investigate the processual nature of resource integration and mechanisms of how resources may intermingle and so forth. Future studies could also deepen the investigation of how social capital, trust and relationship enable/restrain resource integration among multiple actors.

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